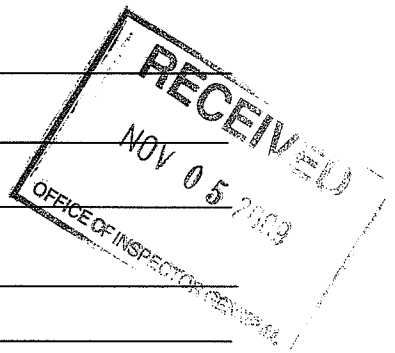
Emailed validation letter 12/1/09

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 11.5.09
Amount $525/1735. Ch# 448190



I. IDENTIFICATION

Name: Appalachian Regional Healthcare, Inc., d/b/a Williamson ARH Nursing Facility

Address: 260 Hospital Drive

City/County/Zip: South Williamson / Pike / 41503

Telephone number: (606) 237-1725

Administrator: Tim Hatfield, CCEO thatfield@arh.org

Date facility operation began at current address: 06/28/1963

Date facility began operation under current owner: 06/28/1963

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled	0	0
Nursing Home	0	0
Nursing Facility	35	35
Intermediate Care	0	0
ICF/MR	0	0
Personal Care	0	0

II. CONTROL (check one in each column)

State	Profit	Individual
County	Nonprofit	Partnership
City		Corporation
Private		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Appalachian Regional Healthcare, Inc.
2285 Executive Drive, Suite 400
Lexington, KY 40505

(OVER)

11/30

If facility owned or leased by a corporation, complete the following:

Name of corporation Appalachian Regional Healthcare, Inc.

Address of corporation 2285 Executive Drive, Suite 400, Lexington, KY 40505

President or Chairman Jerry W. Haynes, President & CEO

Vice President _____

Secretary _____

Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

SEE ATTACHMENT

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
_____	_____
_____	_____
_____	_____

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Signature of authorized representative	Title	Date
_____	President & CEO	11-2-09

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)

Appalachian Regional Healthcare

The Medical Centers of the Mountains

BOARD OF TRUSTEES

2008-2009

Russell Bentley
[redacted]

Emmett S. Pugh, III
[redacted]

Ida Androwich, PhD, RN, FAAN
[redacted]

Raymond Cox
[redacted]

Kathleen Dalton, PhD
[redacted]

Ahmed D. Faheem, MD
[redacted]

Deborah T. Harris
[redacted]

Leon Hollon
[redacted]

Maria A. V. Hortillosa, MD
[redacted]

Thomas K. Hyatt
[redacted]

William May
[redacted]

Larry K. Meador
[redacted]

Timothy C. Mosher
[redacted]

Wayne Myers, MD
[redacted]

John Pellegrini, M.D.
[redacted]

James Shoffner
[redacted]

Richard A. Sturgill
[redacted]

Carolyn Sundy
[redacted]